# DELAWARE HEALTH AND SOCIAL SERVICES

# Division of Public Health

# **Health Systems Protection Section**

# Medical Marijuana Program



# *Instructions and Application For*

# Registration as a Medical Marijuana Patient

Applicant - Print Name (First/MI/Last)	

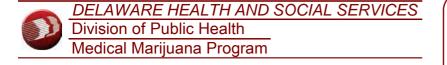
# Applications are NOT accepted in Person. All applications must be mailed to the Department.

#### **MAIL TO:**

Delaware Division of Public Health ATTN: Medical Marijuana Program Suite 205 / HSP ADM 417 Federal Street Dover, Delaware 19901

**** FOR OFFICE USE ONLY ****		
Approved By:		
Date of Approval:		
Registration Number:		

Revised August 3, 2012 drb



Mail to: Delaware Division of Public Health
ATTN: Medical Marijuana Program
Suite 205 / HSP ADM
417 Federal Street
Dover, Delaware 19901

Please note that this checklist, information and other instructions may change. Please refer back to the Delaware Health and Social Services (DHSS) website for the most current information. Review this checklist prior to submitting your application. This checklist will assist you in compiling the required information and supporting documentation. Updates to the program and contact information can be found at the program's website (http://dhss.delaware.gov/dhss/dph/hsp/medmarhome.html).

	Application checklist
_	PATIENT WITHOUT CAREGIVER
	Qualifying Patient Application (attestation statement must be signed)
	Physician Certification (completed and signed by the patient's physician)
	Patient Application Fee (non-refundable) in the amount indicated in the schedule of fees (Payment
_	in the form of a personal check or cashier's check, payable to State of Delaware, Medical
	Marijuana Program)
	Release of Medical Information form (signed by the patient)
	<b>Copy</b> of Delaware state driver's license or state-issued identification (bring original for visual
	inspection when you have your photograph taken)
	PATIENT WITH CAREGIVER
′г	Qualifying Patient Application - Attestation statement must be signed
	Physician Certification (completed and signed by the patient's physician)
	Patient Application Fee ( <b>non-refundable</b> ) in the amount indicated in the schedule of fees ( <b>Payment</b>
	in the form of a personal check or cashier's check, payable to State of Delaware, Medical
	Marijuana Program)
	Release of Medical Information form (signed by the patient)
	<b>Copy</b> of Delaware state driver's license or state-issued identification (bring the original for visual
	inspection when you have your photograph taken)
	Qualifying Caregiver Application - attestation statement must be signed
	Caregiver Application Fee ( <b>non-refundable</b> ) in the amount indicated in the schedule of fees
	(Payment in the form of a personal check or cashier's check, payable to State of Delaware,
_	_Medical Marijuana Program)
	Patient Authorization form (authorizing caregiver to assist the patient in the transportation of medical
_	marijuana)
	<b>Copy</b> of Delaware state driver's license or state-issued identification for the caregiver

**Copy** of caregiver's birth certificate (verifying caregiver applicant is at least 21 years old)

(for further information, contact the program)

Statewide and nationwide criminal history screening background clearance reports for the caregiver

## **Registration Requirements**

#### **REQUIREMENTS FOR PATIENTS**

The following requirements are for people who wish to register with the Delaware Medical Marijuana Program as a qualified patient.

- \* Must be a DE resident and have a Delaware state-issued driver's license or identification Card.
- \* Must be at least 18 years of age to apply for a patient registration.
- \* Must complete and sign the qualifying patient application.
- \* Must be diagnosed with one of the qualifying debilitating conditions listed on the application.
- \* Must have the patient's physician complete and sign a Physician Certification form.
- \* Must submit a Release of Medical Information form to allow the program to verify their medical condition with the certifying physician.
- \* Must submit a non-refundable application fee with the application. (See schedule of fees for details.)
- \* May designate one caregiver and submit caregiver application and supporting documentation along with the patient's application. (See Requirements for Caregivers section).

## REQUIREMENTS FOR CAREGIVERS

The following requirements are for people who have been selected by a Medical Marijuana Program patient to help them with transportation of marijuana, and wish to be registered in the Delaware Medical Marijuana Program as a caregiver.

- \* Caregiver information and applications are ALWAYS provided by the patient.
- \* Must be a DE resident and have a Delaware state-issued driver's license or identification Card.
- \* Must be at least 21 years of age to apply for a caregiver registration.
- \* Must complete and sign the qualifying caregiver application.
- \* Must have patient sign the Patient Authorization for Caregiver form, authorizing the caregiver to assist the patient with the transportation of marijuana.
- \* Must submit a non-refundable application fee with the application. (See schedule of fees for details.)
- \* Each caregiver may be responsible for up to five (5) patients, including themselves if they are also a patient.

## **Rules and Regulations**

#### **GENERAL INFORMATION**

#### **Processing Time:**

The application process can take 8-12 weeks depending on the individual circumstances; however, it is the intention of the program staff to disperse cards within 4-6 weeks from the date the completed application is accepted.

#### **Confidentiality:**

For confidentiality purposes, information regarding application status will NOT be given over the phone. Once applications are approved, a letter will be mailed to the applicant including an appointment time to have a photo taken and finalize the application process.

#### **Information Changes:**

By law, Medical Marijuana patients are required to provide DHSS with any changes in application information, such as address, phone number, chosen caregiver, etc. within 10 days of the change. After a registration card is issued, information changes will be made by completing a Change Form, available online at the program website at:

#### http://dhss.delaware.gov/dhss/dph/hsp/medmar.html.

#### **Card Replacement:**

There is a \$20.00 fee to print a new card. Any information on a registry card that has changed, such as address, requires a new card to be printed. If a card is lost, it will also require a reprint. Please notify DHSS immediately if a registration card is lost. The program will issue a different identification number and schedule an appointment time to issue a replacement card.

## Fines Established for Not Following the Program Regulations:

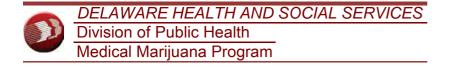
Fines are established in the Medical Marijuana Act for registry participants who do not follow the rules and regulations of the Medical Marijuana Program. They are listed below for your information.

Failure to notify program staff of patient or caregiver changes	\$ 150.00
Selling marijuana to a non-card holder	\$ 2,000.00
Fraudulent card creation or use	\$ 1,150.00
Unethical professional conduct	\$ 3,000.00

#### **FEE SCHEDULE**

The following fee schedule has been established for the program. Applicants must include payment, in the form of a personal check or cashier's check, payable to State of Delaware, Medical Marijuana Program, with the application, mailed to the address on the first page of this packet. If you believe that you qualify for the low income sliding fee schedule, please contact our office for more information.

Patient Application Fee - registration effective for one year	\$ 125.00
Caregiver Application Fee - registration effective for one year	\$ 125.00
Patient Renewal Fee	\$ 125.00
Caregiver Renewal Fee	\$ 125.00
Return Check Fee	\$ 35.00
Replacement Card Fee (lost card, name or address change, etc.)	\$ 20.00



DPH/HSP office use only		
Date Received	Issue Date	
Staff Initials	<ul> <li>Expiration Date</li> </ul>	
Approved Denied	App/Den Date	

Please <u>print</u> clearly. Incomplete applications will be denied. Denied applicants are required to wait six months before applying again with another application fee. Please put "N/A" if not applicable. Application fees are non-refundable. **Faxed and electronic copies will not be accepted.** 

	ie. Paxeu and electr	Patient Applica		
New Patient	Renewing Patier		ent Registry ID Ca	rd #
		CONTACT INFORM	ATION	
Date of birth Must be at least 18	mm / dd / yyyy	Gender		male
<u>Name</u>				
NameTitle	First	Middle initial	Last	Suffix(es)
(This name must match	the name on your State Is	ssued Photo ID or Driv	er's License.)	
Residence address	*	below must be your pl	nysical residence and	will appear on your registry card.
Apt#/development				
Street address/pos				
City		State	County	ZIP code
Mailing address Apt#/development	/apartment name	ng address is the s	ame as residentia	l
Street address/pos		Ct. 1	<u> </u>	ZID 1
City		State	County	ZIP code
	nbernber	Tyj		e, cell)e, cell)
result in your application be safe senders to avoid having	ing delayed, withdrawn or deni	ed. It is the applicant's res ail folder. Instructions on h	ponsibility to add <u>Medica</u> ow to add an e-mail addre	address. Failure to respond to e-mails may alMarijuanaDPH@state.de.us to their list of ess to your list of safe senders can be found
	(D			
	P	HYSICIAN INFORM	IATION	
patient's debilitating m	edical condition is Post-T	'raumatic Stress Disor	der, the physician m	Certification form. If the qualifying ust also be a licensed psychiatrist. d can be copied from there.
Title	First	Middle initial	Last	Suffix(es)
Practice/group nan	1 <b>e</b> (if applicable)			
Address (suite/roo				
Number & street				
City, state, & zip				
Phone number		Fax nun	nber	
License number		License s	tate Lice	ense type
Length of time the p	oatient has been unde	r the care of this P	hysician (years &/o	or months)

DEBILITATING MEDICAL CONDITION
Patient's Debilitating Medical Condition (please check all that apply)
Cancer Positive status for human immunodeficiency virus (HIV positive) Acquired immune deficiency syndrome (AIDS) Decompensated cirrhosis (Hepatitis C) Amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) Agitation of Alzheimer's disease Post-traumatic stress disorder (PTSD) (physician MUST be a licensed psychiatrist)
A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:  Cachexia or wasting syndrome Severe, debilitating pain, that has not responded to previously prescribed medication or surgical measures for more than 3 months or for which other treatment options produced serious side effects Intractable nausea Seizures Severe and persistent muscle spasms, including but not limited to those characteristic of multiple
Any other medical condition or its treatment <b>added by DHSS</b> as provided for in 4906A of the <a href="Delaware">Delaware</a> code. Please specify below.  Other: please specify
CAREGIVER INFORMATION
This group of questions relate to the patient's designated caregiver. A patient does not have to choose a caregiver, but if caregiver is chosen, the caregiver must also apply for a registry identification card along with the patient. A caregiver can have up to five patients, including themselves if they are a qualifying patient, that they are caring for with regards to this program. visiting patient may not assign a caregiver or be a caregiver for another patient.  Check here if you are not requesting a caregiver, then go to the next section.  Name
Title First Middle initial Last Suffix(es)
Address Apt#/development/apartment name Street address/post office box #
City State County ZIP code
Phone number  Date of birth  mm / dd / yyyy  Phone type (cell/home)  Gender  Male  Female
Relationship to applicant:

VOLUNTARY	DEMOGRAPHIC	INFORMATION
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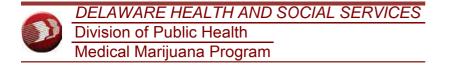
Please check the items that apply. It is the policy of the state of Delaware to assure equal and fair treatment in all aspects of healthcare for all of our residents. The information on this page will only be used to document and assess the effectiveness of our outreach and will not be used for eligibility determination. Your voluntary answers are requested. Thank you.

	What is your current marital status?
<u>Marital</u> <u>Status</u>	aSingle bMarried/Civil Union cDivorced
<u>status</u>	d. Separated e. Widowed f. Unmarried partnership
<b>Ethnicity</b>	Which of the following best describes your ethnicity?
	a Hispanic or Latino b Non-Hispanic or Latino
<u>Race</u>	Which of the following best describes your racial heritage?
	aCaucasian/White dAfrican American/Black
	bAsian eAmerican Indian or Alaska native
	cNative Hawaiian or pacific islander fOther
<u>Language</u>	How well do you speak English?
<u> Language</u>	aVery well bWell cNot well dNot at all
	Do you speak a language other than English at home?
	aNo bYes, Spanish cYes, not Spanish, please specify:
<u>Veteran</u>	Are you a United States veteran?
<u>Status</u>	aYes bNo
Citizenship	Are you a citizen or lawful resident of the United States of America? aYes bNo
<u>Education</u>	What is your highest level of education completed?
	aHigh school last grade completed dTechnical school
	b. High school diploma/GED e. University or 4-year college
	c. Community college/2-year degree f. Master program or above
	Are you currently enrolled in school?
	a. No b. Yes If yes, what level?
	<u> </u>
<b>Employment</b>	Are you currently working? a No b Part Time c Full Time
	What is your occupation?
_	
<u>Income</u>	What is your annual household income?
	aLess than \$20,000 d\$60,000 to \$79,999 b. \$20,000 to \$39,999 e. \$80,000 to \$99,999
	b \$20,000 to \$39,999 e \$80,000 to \$99,999 c \$40,000 to \$59,999 f \$100,000 or above
	1 \$100,000 to \$35,555
<u>Public</u>	Are you currently enrolled in a public assistance program such as the DE food supplement
<u>Assistance</u>	program, health insurance, child care assistance, energy assistance program, or any other
	public assistance program?
	a. No b. Yes Which program(s)?

# LOW INCOME CHARGE REQUEST

If you believe that you qualify for the low income fee schedule, and wish to be considered for a lower application fee, you must provide supporting financial information, such as copies of your most recent tax returns, copies of W-2 forms, other documents showing current income. Total annual gross household income and the number of people living in the household will be requested in order to approve a reduced rate. To avoid denial of your application or delay in processing, please call the program to request a low income packet.

	REQUIRED DOCUMENTS	
These documents must be submit	ted with your patient application:	
Delaware driver's license or state-		
ID number	• • •	Expiration date
<u> </u>	Issue date mm / dd / yyyy	mm / dd / yyyy
	license OR state-issued photo identification is the available for visual inspection when	on card should be <u>sent</u> with the application registry card is issued.
Medical information release co	nsent form	
Physician certification - enter d	ate written (must be within 90 days of a	
		mm / dd / yyyy
	ou must also submit the following o	documents for that caregiver:
Delaware driver's license or state-	_	Emination data
ID number	ISSUE date mm / dd / yyyy	Expiration date
	cate (verifying caregiver applicant inal history screening background	
P	PATIENT'S ATTESTATION STATEM	ENT
I hereby certify that all of the initial best of my knowledge.	e information provided on this appl	ication is true and accurate to the
I agree to notify the Medical l	,	the "Change Form"), within 10 days
	marijuana to any individual or entit 16 of the Delaware Code, Chapter 4	
Patient sig	nature	Date of signature



DPH/H	ISP office use only
Date received	Physician verified in
Staff initials	good standing?
Date verified	Yes
Staff initials	_

Please <u>print</u> clearly and answer all of the questions. Patients, please have your physician complete the entire form. This form should be submitted with your Application to the Medical Marijuana Program at the address on the first page of application instructions. **Faxed and electronic copies will not be accepted. NOTE: This does NOT constitute a prescription for marijuana. The patient's application for the medical marijuana program must be received by DPH within 90 days of the signature date on this form.** 

Physician Certification					
	PATIENT INFORM	IATION			
Physician instructions: please complete this section with the information in the patient's record.					
Name Title First	Middle initial	Last	Suffix(es)		
Patient's address	Middle illidai	Last	Sunix(es)		
Apt#/development/apartment name Number & street					
City	State	County	ZIP code		
Patient's date of birth		t's phone number	<u> </u>		
mm / dd / yyyy	,				
DEBILITATING MEDICAL CONDITION					
Positive status for human immunodeficiency virus (HIV positive) Acquired immune deficiency syndrome (AIDS) Decompensated cirrhosis (Hepatitis C) Amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) Agitation of Alzheimer's disease Post-traumatic stress disorder (PTSD) (physician MUST be a licensed psychiatrist) A chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following: Cachexia or wasting syndrome Severe, debilitating pain, that has not responded to previously prescribed medication or surgical measures for more than 3 months or for which other treatment options produced serious side effects Intractable nausea Seizures Severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis  Any other medical condition or its treatment added by DHSS as provided for in 4906A of the Delaware code. Please specify below.  Other: please specify					

PHYSICIAN INFORMATION
<u>Name</u>
Title First Middle initial Last Suffix(es)  Practice/group name (if applicable) Address (suite/room number, etc.) Number & street
City, state, & zip Phone number Fax number Fax number
Phone number Fax number  License number License state License type  Email address (not required)
Length of time the patient has been under your care (years &/or months)
PHYSICIAN CERTIFICATION
I,
initials
Have established a bona fide physician-patient relationship with (patient)  This qualifying patient is under my care, either for his/her primary care or for his/her debilitating medical condition as is listed on this form. This bona-fide physician-patient relationship is not limited to authorization for the patient to use medical marijuana or consultation for that purpose.
initials  Have conducted an in-person physical examination of the qualifying patient within the last 90 calendar days. I completed an assessment of the qualifying patient's current medical condition, including presenting symptoms related to the debilitating medical condition I diagnosed or confirmed.
Have completed an assessment of the qualifying patient's medical history, including medical records from other treating physicians from the previous 12 months. I have established a medical record for the qualifying patient with regard to his/her medical condition, and his/her continued treatment under my care.
initials
Have explained the potential risks and benefits of the medical use of marijuana to the qualifying patient.
Physician's attestation  I,, hereby certify that I am a physician duly licensed to practice medicine. It is my professional opinion that the qualifying patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the qualifying
patient's debilitating medical condition or symptoms associated with the debilitating medical condition. Further, it is my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks for this patient. I attest that the information provided in this written certification is true and correct.
Physician's signature (no signature stamps accepted, blue ink only)  Date of signature

	DELAWARE HEALTH AND SOCIAL SERVICES
	Division of Public Health
	Medical Marijuana Program

DPH/HSP office use only				
Date received	Patient verified with			
Staff initials	certifying physician?			
Date verified	Yes No			
Staff initials				
_				

Patients, please complete and sign the following release statement. This form will allow the Medical Marijuana Program staff to verify information with the certifying physician relating to your qualified medical condition. This form must be submitted with your patient enrollment application. If this form is omitted, your application will be considered incomplete and will be denied. **Faxed and electronic copies will not be accepted.** 

Release of Medical Information Form				
PATIENT RELEASE R	EQUEST			
/I,	patient's name):			
hereby authorize the Delaware Department of Health and				
discuss my medical condition, including treatment records	,			
	patient's qualifying condition)			
with my certifying medical provider (print certifying medical	cal provider's name below)			
(Physician's first name:) Last	name:			
and, if applying under post-traumatic stress disorder, m	y licensed psychiatrist			
(Psychiatrist's first name:)Last	name:			
I understand that I may revoke this release at any time. I also understand that if I wish to revoke this				
authorization, I must do so in writing to the Delaware Medical Marijuana Program, and that revocation				
may result in the inability of the program to certify me as a Medical Marijuana Program participant.				
Additionally, I understand that the revocation will not	apply to information that has already been			
released in response to this authorization. The informat	ion disclosed pursuant to the authorization is			
subject to potential re-disclosure by the recipient, and will not be protected by the HIPAA privacy rule. I				
understand that this disclosure is voluntary and that si	gning this form is not necessary in order to			
receive treatment from the Delaware Department of Healt	h and Social Services. This release is required;			
however, to verify my eligibility for the Medical Marijuana	Program.			
By signing this release I certify that I am aware that	the program may provide verification of my			
enrollment status with law enforcement; but only for the purpose of verifying that a person is lawfully				
enrolled in the Medical Marijuana Program, or in the event that the Medical Marijuana Program				
administrator or designee has reason to believe that a qualified patient-applicant may have violated an				
applicable law.				
This authorization will expire in one (1) year unless a	different expiration date prior to one year is			
specified here: / / .				
Patient's signature	Date of signature			